

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

- Section I Employer's Statement** - to be completed by the **employer's** authorized representative.
- Section II Employee's Statement** - to be completed by the **employee** who is applying for Short Term Disability Benefits
- Section III Authorization to Obtain Information** - to be signed by the **employee**.
- Section IV Attending Physician's Statement** - to be completed by the Healthcare Provider who is treating the **employee**.

Fax completed application to:

The Hartford
P.O.Box 14301
Lexington, KY 40512-4301
Fax Number: (866) 411-5613

Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR HARTFORD BENEFIT MANAGEMENT SERVICE CENTER.

Fax completed application to:
The Hartford
P.O.Box 14301
Lexington, KY 40512-4301
Fax Number: (866) 411-5613

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS



Section I - Employer's Section

To Be Completed by the Employer

This claim is for (Employee's Name)	Social Security Number	Date of Birth
Employee's Address (Street, City, State, Zip)	Telephone Number ()	

A. Information About the Employer

Company's Name		
Address (Street, City, State, Zip)		
Name and Address of Division Where Employee Works (if different from above)		
Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired	Date employee became insured under this plan	Is the employee a union member? Yes No If Yes, name of union and local number:
What was the employee's regularly scheduled work week? _____ Hours per Week _____ Scheduled workdays M - F Other: _____		
IS EMPLOYEE ENROLLED IN THE HARTFORD'S LONG TERM DISABILITY PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," EFFECTIVE DATE _____		
Was the employee's STD insurance issued on the basis of a Personal Health Statement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes, attach copy.		
Was the employee insured under your prior STD policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the inclusive date of coverage. From _____ Through _____		
Was the employee on Qualified Family Leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did STD & LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date Leave of Absence started under Family Leave Act: _____		

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? _____ %.
What percentage, if any, do you contribute towards the cost of the STD premium? _____ %
Does the employee contribute towards the cost of the STD premium? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "Yes," at what percent? _____ %.
Is it on a <input type="checkbox"/> Pre or <input type="checkbox"/> Post-tax basis?
What percent of this employee's LTD benefits is taxable? _____ %
Does the employee contribute towards the cost of the LTD premium? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "Yes," at what percent? _____ %
Is it on a <input type="checkbox"/> Pre or <input type="checkbox"/> Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)	
Last day employee actually worked:	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," how many hours were worked? _____
Why did employee stop working?	
Is the employee's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a claim been filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected to return to work? _____ Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No

E. Information About Salary

Employee's weekly/hourly rate of pay: \$ _____

Will/Is Employee receive(ing) Workers' Compensation Payments? Yes No

Weekly Amount: \$ _____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance? Yes No or Sick Leave?

Weekly Amount: \$ _____ Date Payments Start: _____ Date Payments Will End: _____

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day		If sporadically circle time for each section below															
					Hours at one time								Total hours/8 hour							
Sit	<input type="checkbox"/>	or	<input type="checkbox"/>		1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>	or	<input type="checkbox"/>		1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>	or	<input type="checkbox"/>		1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Can the job be performed alternating sitting and standing? Yes No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending at Waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling/Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)

Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? Yes No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)?

Yes No If "Yes," explain.

H. Signature

_____ <i>Name</i> (Please print or type)	_____ <i>Title</i>
_____ <i>Signature</i>	_____ <i>Date</i>
() _____ Area Code Telephone Number	() _____ Area Code Fax Number

Fax completed application to:
The Hartford P.O. Box 14301
Lexington, KY 40512-4301
Fax Number: (866) 411-5613

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS



Section II - Employee's Section

To Be Completed by the Employee (BE SURE TO ANSWER
ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Last name:	First:	Middle Initial:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:
Address: (Street, City, State & Zip)			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Personal Cell Telephone Number: ()			Alternate Telephone Number: ()		
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Signature			Date		
E-Mail Address: _____					
E-Mail is used to provide The Hartford At Work registration instructions and important status updates.					

B. For an Injury, answer the following questions

When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Name of Healthcare Provider:	Date you were first treated by a Healthcare Provider: (MM/DD/YYYY)
Address of Healthcare Provider: (Street, City, State & Zip)	Telephone Number: ()
Before you stopped working, did your condition require you to change your job, or the way you did your job? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain: _____	
What aspect of your condition made you unable to work? _____	
Are you receiving or eligible for: <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability <input type="checkbox"/> No Fault Disability <input type="checkbox"/> Other _____ If "Yes," show policy number: _____ and name and address of insurer: _____	
Weekly Amount: \$ _____ Date Payments Start: _____ Date Payments Will End: _____	
Is your condition related to work activities or your workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain: _____	
Have you filed, or do you intend to file a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain: _____	

D. Information About the Disability

Last day you worked before the disability:	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain: _____
Your Employer: (include division, if applicable) _____	
If you have not returned to work, do you expect to? <input type="checkbox"/> Yes <input type="checkbox"/> No Date you were first unable to work: _____	
Since that date, have you done any work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time <input type="checkbox"/> Full time If "Yes," please indicate dates worked, name of employer and amount earned: _____	
Name of employer and amount earned: _____	

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is \$ 20.00 per week). \$ _____ 00. **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www .irs.gov to obtain the proper withholding form.

F. Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____

Date _____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.



I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford, the following personal, private, or privileged information, records, or documents:

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud (all entities and individuals listed herein including The Hartford defined as "Benefits Manager(s)")

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records.

Therefore:

- If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.**
- If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program.**

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I know I can see or copy the records given to The Hartford based on this Authorization. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

Claimant's Name

Date of Birth

Employer's Name

Date

Claimant's (or Legal Representative's) Signature

Legal Representative's Name and Relationship

Form must be signed in order to be considered valid.

Please fax the completed form to:
Fax Number: 866-411-5613
The Hartford
P.O.Box 14301
Lexington, KY 40512-4301
Email: APSupload@thehartford.com

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT



To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:
---------------	----------------	--------------------

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: Sickness Injury Pregnancy

If pregnancy, what is the expected date of delivery? _____
Month Day Year

Is condition due to illness or an injury that is related to: Work Activity Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: _____
ICD- 10 Code: _____

Secondary condition(s): _____ ICD-9 Code: _____
ICD-10 Code(s): _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? Yes No Is surgery planned? Yes No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? Yes No If "Yes," Date(s) admitted: _____ Date(s) Discharged: _____

Name of Hospital: _____ Telephone Number of Hospital: () _____

Has patient been referred to any other physician? Yes No If "Yes," Date(s) of Referral: _____

Other Physician Name: _____ Phone Number: () _____ Specialty: _____

Other Physician Name _____ Phone Number: () _____ Specialty: _____

The Hartford® is underwriting companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Patient Name:

Date of Birth:

Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: Right Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): Recovered Improved Unchanged Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? Yes No If "Yes," please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? Yes No

Provider's Name: (please print or type) _____ EIN Number: _____ License Number: _____

Telephone Number: () _____ Fax Number: () _____ Degree: _____ Specialty: _____

Street Address (Street, City, State & Zip Code): _____

Office Contact and Telephone Number: _____

Provider's Signature: _____ Date signed: _____